

Clarke, Patrice A

From: Walk, Roger A.
Sent: Monday, December 02, 2002 9:02 PM
To: Clarke, Patrice A
Subject: Fw: [SRNTLIST] Smokeless Tobacco and Harm Reduction

new active file

Pls print
Roger Walk
Sent from my BlackBerry Wireless Handheld (www.BlackBerry.net)

-----Original Message-----

From: Adams, Candace R. <Candace.R.Adams@pmusa.com>
To: Walk, Roger A. <Roger.A.Walk@pmusa.com>
Sent: Mon Dec 02 13:56:05 2002
Subject: FW: [SRNTLIST] Smokeless Tobacco and Harm Reduction

FYI

-----Original Message-----

From: Brad Rodu [mailto:brodu@PATH.UAB.EDU]
Sent: Monday, November 04, 2002 5:44 PM
To: Multiple recipients of srntlist
Subject: [SRNTLIST] Smokeless Tobacco and Harm Reduction

Over the past decade we have published research that provides the scientific foundation for a harm reduction strategy to help inveterate cigarette smokers to quit. This strategy promotes permanent nicotine maintenance for such smokers, including the use of smokeless tobacco (SLT) products. Several criticisms of this strategy have been offered at meetings and in electronic forums. These criticisms have the following general themes: (1) The differential health risks between SLT and cigarettes are unclear, so there is no scientific rationale for substituting the former for the latter; (2) there is no evidence that this strategy works on a practical level; and (3) SLT use may serve as a "gateway" to smoking, making the strategy unacceptable because it would influence the young to begin SLT use and thus be more likely to become smokers.

As many SRNT members may not be familiar with SLT use and its potential application to smoking cessation, this communication provides them with some background research on this issue and discusses the criticisms. We hope that this communication to SRNT members will stimulate interest and research in this and other approaches to harm reduction for smokers. Anyone interested in collaborating on projects related to this work is invited to contact us.

SLT is much less harmful than cigarettes

We reported that SLT use imposes only about 2% of the mortality risk of smoking (Am J Med Sci 308: 32-34, 1994; Technology 6: 17-21, 1999). For example, linking SLT use to oral cancer even with a relative risk of 8 (up to four times the risk of current products) and applying that excess risk at all ages after 35 years (even though SLT-associated oral cancer generally occurs at ages over 70 years), we found that the reduction in life expectancy from SLT use would be only 0.04 years (15 days) (Nature 370: 184, 1994). In comparison, continuing smokers lose an average of 7.8 years of life. We extended these findings in another study of the life expectancy of men and women smokers of various ages who quit or who switch to SLT (Epidemiology 7: 111-112, 1996). In addition, we have reviewed other aspects of SLT use and its substitution for cigarettes (Oral Surgery 80: 178-182, 1995), and we have described a group of former smokers who quit on their own using SLT (J Psych Drugs 27: 173-175, 1995).

Does SLT use lead to health problems other than oral cancer?

Perhaps. There is debate about whether SLT use is associated with cardiovascular diseases, based on two negative (BMJ 305: 1252-1256, 1992; J Am Coll Cardiol 34: 1784-1790, 1999) and one positive study (Am J Public Health 84: 399-404, 1994) from Sweden. But these or any other risks are likely to be very small, and certainly far less than those resulting from smoking. Whether SLT use ultimately is found to have two, four or even ten percent of the risks from smoking can not alter the strong scientific and public health rationale for an SLT-based harm reduction strategy. Kozlowski et al. presented a risk/use equilibrium model that made a compelling case for employing medicinal nicotine in harm reduction (Tobacco Control 10: 201-203, 2001). This model supplements our case for employing SLT in harm reduction (Technology 6: 17-21, 1999).

Data suggest that a harm reduction strategy employing SLT would work.

Arguments against the practical implementation of this strategy range from contentions that SLT products are socially unacceptable to assertions that there is no evidence that SLT would help smokers quit. One rather inane argument against the practical implementation of our strategy goes something like this: smokers will never use disgusting "spit" tobacco. First, the term itself is insensitive and inappropriate when used by health professionals, because it is demeaning and degrading both to current SLT users and to smokers who may wish to try this strategy. Second, and more importantly for this issue, the term is incorrect, because new products can be used invisibly and are more discreet than chewing gum.

In 1998 we published the first trial assessing SLT substitution as a quit-smoking method (Am J Med 104: 456-458, 1998). We acknowledge that this was a non-randomized pilot study with small numbers of subjects. However, SLT substitution was successful in 25% of inveterate smokers who had failed repeatedly to quit (most had tried prescription nicotine gum or patches). Long-term follow-up of this group suggests that SLT substitution is sustainable (manuscript submitted). Are additional studies needed? Of course. Clinical trials can address questions about short and long term efficacy and social acceptability of SLT products for smoking cessation and nicotine maintenance.

Data from Sweden support the role of SLT in harm reduction at the population level. For the past 50 years men in Sweden consistently have had the lowest smoking prevalence and the highest SLT prevalence in Europe. A new study from northern Sweden shows that these tobacco use patterns are related (J Int Med 252: 398-404, 2002). While the overall prevalence of current tobacco use among men was stable between 1986 and 1999 (~40%), the prevalence of smoking was 19% in 1986 and 11% in 1999, while the prevalence of SLT use was 18% in 1986 and 27% in 1999, with combined users (smoking + SLT use) at 3 to 5 %. In fact, throughout this period smoking was less prevalent among men than among women, an inverse of the pattern seen in virtually every other society in the world. In addition, SLT use was the dominant factor in higher ex-smoking rates among men than among women.

SLT is not a gateway to smoking

There have been reports of transitions from SLT use to smoking in certain populations (Preventive Medicine 32: 262-267, 2001; Am J Prev Med 23: 143-149, 2002). We will not discuss here the methodological issues in gateway research generally or in these papers specifically. Instead, we point out that for twenty years the dominant public health message has been that SLT use is as dangerous as smoking. This erroneous, even dangerous, message is reinforced by the mandated warning on packages of SLT ("This product is not a safe alternative to cigarettes"). Unfortunately, too many smokers have accepted this message and continue to smoke. Recent reports of the "gateway" effect show only that some SLT users also have accepted it and have switched to cigarettes.

The case for harm reduction is compelling, as the diseases caused by smoking remain a terrible burden on society. Earlier this year we estimated that there now about 24 million inveterate smokers in the US, despite anti-smoking measures of increasing intensity over the past 40 years (Int J Cancer 97: 804-806, 2002). The status quo in smoking control is unacceptable. Harm reduction should receive serious consideration now.

Copies of our published papers are available upon request from BR at
rodu@uab.edu.

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Disclosure: www.uab.edu/smokersonly (See Financial Support)

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